## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  R-C 01/28/2016	
		15A011	B. WING				
NAME OF PROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				2325 S MILLER ST			
ESPECIALLY KIDZ HEALTH & REHAB				SHELBYVILLE, IN 46176			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	00 INITIAL COMMENTS		F	000			
	Paper compliance to Complaints IN001845 IN00188449 complete						
	Review date: January 28, 2016						
	Facility number: 000273 Provider number: 15A011						
	AIM number: 100267870						
	be in compliance with B and 410 IAC 16.2,	h and Rehab was found to n 42 CFR Part 483, Subpart in regard to the paper the complaint investigation.					
	Quality review comple 28, 2016.	eted by 30576 on January					
I ARORATORY	DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATU	DE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.